STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151583	A. BUILDING _____ B. WING _____	R 12/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOSPICE OF NORTHWEST INDIANA LLC	**7020 BROADWAY MERRILLVILLE, IN 46410**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{L 000}	INITIAL COMMENTS This was a revisit for a Hospice federal recertification and state relicensure survey conducted 11/19/12 which resulted with Conditions being cited. Survey date: 12/27/12 Facility #: 002379 Medicaid Vendor #: 200461590 Surveyors: Ingrid Miller, RN, PHNS Janet Brandt, RN, PHNS Unity Hospice of Northwest Indiana was found to be in compliance with IC 16-25-3 and the Conditions of Participation 42 CFR Part 418. Census: 85 patients admitted in last 12 months Quality Review: Joyce Elder, MSN, BSN, RN January 2, 2013	{L 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.